Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period April 2005-June 2005

Introduction

This report presents the fourth quarter of fiscal year 2005 (April 2005-July 2005) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The information used for this report is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analyses of data provides information that allows stakeholders to determine how well CAMHD is delivering care and impacting child outcomes.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected and Used

CAMHD has successfully used performance measures over a number of years. The key utility of measuring quality and performance is the ability it gives to align organizational goals with achieving results in core areas of service provision and supporting infrastructure. CAMHD worked through a process of moving from "fear of accountability" and measurement, to counting on the data to allow for open discussion about needed improvements. Measures are used to coordinate the work of the organization in order to achieve timely, cost-effective services that ultimately improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD at all levels to look at its performance and use this information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system is performing for youth,

and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Sustaining the Gains Made Through the Felix Consent Decree

On May 31, 2005, the State of Hawaii was deemed to be in compliance with the terms of the Felix Consent Decree. There were a number of catalysts that helped the State build and maintain a system of care for children and families. A core component of the Consent Decree was the requirement to develop quality assurance practices. Continuous quality improvement, a foundational component of any service delivery system, is a central system commitment.

There are two primary vehicles for implementing continued refinements to the children's mental health service system. The Hawaii State Legislature through HRS §321-175 requires CAMHD to implement a Strategic Plan that outlines the direction and priorities for children's mental health in Hawaii. Now, two and a half years into the current Strategic Plan, CAMHD is actively implementing activities in the five goal areas of shared ownership for CAMHD initiatives, supporting CASSP principles, evaluating and disseminating evidence-based practices, integrating performance monitoring and evaluation throughout the system, and building stronger business practices. A full report on the status of the first two years of the current CAMHD Strategic Plan's implementation can be found at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-4.pdf.

The other means for continuous improvement of services occurs through CAMHD's Quality Assurance and Improvement Program (QAIP). The QAIP is the foundation for CAMHD's performance management activities. Its purpose is to assure youth and families receive the best possible and most appropriate care through qualified staff and providers, and to ensure positive functional outcomes for youth. It includes monitoring of all the types of services provided, clinical quality investigations, and assurances that youth are served in the least restrictive environment possible. Each year, a QAIP Work Plan is developed that outlines the current performance improvement activities, as well as the schedule for implementation. Goals and objectives for the current year are: 1) the provision of services by qualified practitioners, 2) the maintenance of the utilization management program which ensures access, availability and appropriate use of services, 3) quality of care and service provision, 4) consumer satisfaction, 5) delegation oversight for credentialing activities, and 6) minimizing fraud and abuse through the compliance program. A full description of these activities can be found at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-1.pdf and http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-4.pdf.

Current CAMHD initiatives and activities over the last quarter that are supporting the quality goals include:

- CAMHD has received two State Incentive Grants (SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Alternatives

to Restraint and Seclusion SIG allows for the development of best practices in residential treatment programs with the goal of promoting positive alternatives to the use of coercive behavior management interventions. This three-year grant will develop a peer-support network and provide intensive technical assistance to residential programs in CAMHD's service network. A kick-off conference will be held on September 14th and 15th entitled, "Creating Cultures of Engagement in Residential Care."

The other grant is a joint project between CAMHD and the Adult Mental Health Division (AMHD) entitled "Hawaii's State Mental Health Data Infrastructure Grant for Quality Improvement." This three-year project is designed to expand the capacity of these divisions to report the information for SAMHSA's national outcomes measure initiative. In addition, this project is designed to expand the use of performance measure information for system planning across AMHD and CAMHD.

- On May 14, CAMHD co-sponsored Hawaii Families as Allies' annual Family and Youth Conference. This year's conference highlighted inspiring presentations by members of the National Youth Development Board. The youth advocates from across the country spoke to their personal experiences in mental health services systems, and their work in youth advocacy in their communities. The "take-home message" was importance of the voice of youth in shaping service delivery.

  CAMHD will be releasing a Request for Proposal (RFP) in Fall 2005 for a Young Adult Support Organization to provide outreach and support to youth ages 16-21, and will feature young people having core leadership roles.

- CAMHD held its annual Intensive Case Management Conference on May 24 designed to enhance the skills and knowledge of Care Coordinators. The conference featured Karl Dennis and Sue Smith, national leaders in the wrap-around approach, family involvement and community-based care.

- CAMHD is working on two additional initiatives. One is the release of a RFP for Emergency and Intensive Mental Health Services, which involves development of new Interagency Performance Standards and Practice Guidelines with the Department of Education. The other initiative is the Civil Service Replacement Project, which will establish the majority of CAMHD positions as civil service positions per Legislative mandate.

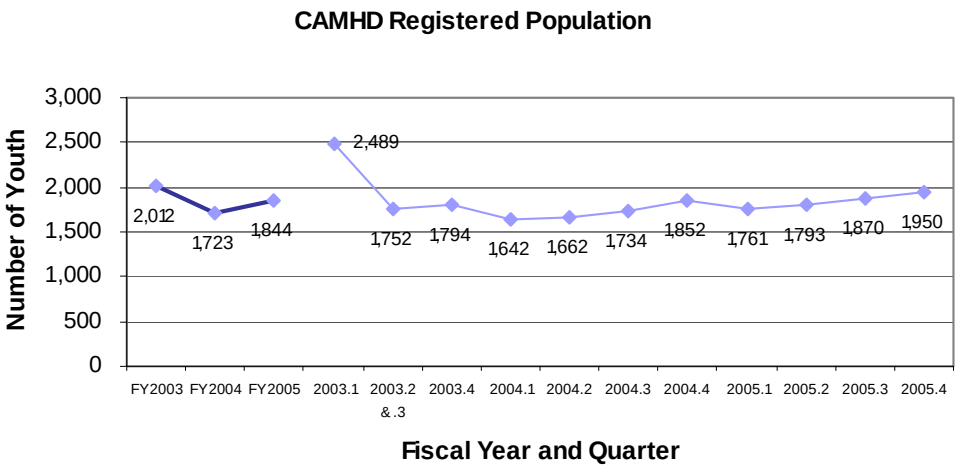
Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the fourth quarter of fiscal year 2005 (April 2005-June 2005). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,950 youth across the State, an increase of 80 from the previous reporting quarter (January 2005-March 2005), or a 4% increase in the total population. Increases in the registered population were experienced in all of the Family Guidance Centers. Since the same period last year (April 2004-June 2004), CAMHD has experienced a 5% overall increase in its registered population.

The chart below reflects changes in the CAMHD population over time. The drop in population at the start of fiscal year 2003 (July 2002) corresponds to the shift in management of services to youth with pervasive developmental disorders from CAMHD to the Department of Education.



Although there has been a slight increase in population over the past year, as noted in the Annual Evaluation for FY 2004, CAMHD serves far fewer youth with severe emotional and behavioral disturbances (SEBD) than would be expected based on the estimated prevalence. Nationally, access to services is most often reported in terms of treated prevalence of those youth with serious mental health or the *penetration rate*, which simply stated is how far did services penetrate into the population that need the services. Based on CAMHD's estimates, penetration rates for QUEST youth, which are generally the population with greater prevalence of intensive mental health issues, are roughly 6 to 29% (depending on FGC catchment area), which means there is a potential unmet need for 81% to 94% of the QUEST youth population with SEBD.

Among the performance improvement recommendations out of the Annual Evaluation for FY2004 to address access to mental health services (http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/ge/ge014.pdf), was the suggestion that CAMHD promote early identification by reviewing and clearly identifying screening mechanisms. One potential avenue for this is the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program that requires both physical and mental health screening. In the most recent data available on the CMS website (FY 2000: http://www.cms.hhs.gov/medicaid/epsdt/ep2000.pdf), Hawaii reported that 73,424 youth between 3 and 18 years of age were eligible for EPSDT services, 39,201 youth between 3 and 18 years of age were eligible for one or more initial or

periodic screenings during the year and that 23,687 (60%) received at least one screening. If, based on a conservative assumption, 3% to 5% of youth were expected to meet SEBD eligibility criteria, then approximately 2,203 to 3,671 youth eligible for EPSDT should meet SEBD criteria, roughly 1,176 to 1,960 youth eligible for screening during the year should meet SEBD criteria, and around 711 to 1,184 youth should be identified. CAMHD could consider promulgating recommended indicators for identifying mental health needs during screening and procedures for follow-up assessments to identify youth when their functioning enters the SEBD eligibility range. Also, as noted above, continued development of the DOH-DOE peer review process was recommended.

Therefore, earlier identification and treatment as system-wide improvements was seen as a key improvement recommendation. The Annual Evaluation found that the average CAFAS scores at registration to CAMHD were approximately 110. Since a CAFAS score of 80 represents the guideline for functional impairment defining SEBD eligibility, this implies that youth are not being identified until their functioning has deteriorated well past the point of eligibility. This may imply that the referral process is crisis focused, that a "gatekeeping" mindset might prevent initiation of services for moderately severe problems, or that systematic surveillance systems are not in place.

The numbers of youth registered at each of the Family Guidance Centers during the fourth quarter (April 2005-June 2005) are displayed in Table 1. The numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) serves the largest population on Oahu, and 12.5% of CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2%).

Table 1. Population of Youth Registered by Family Guidance Center, FY 2005, Quarter 4 (April 2005-June 2005)

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
167	244	167	151	183	471	527	40

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 1,055 had services that were authorized within the quarter.

Of the registered population (1,950), 138 youth (7.1%) were newly registered (had not previously received services) in the fourth quarter of fiscal year 2005. This represents a decrease of 21 new admissions from the previous quarter (January 2005-March 2005). Ninety-seven (97) youth (5.0%) who had previously received services from CAMHD were reregistered, a decrease from last quarter's readmissions of 112 youth. CAMHD discharged a total of 224 youth during the quarter, or 11.5% of the registered population. This is an increase of 87 youth from last quarter's discharge of 137 youth, which was

7.3% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal, or moving out of state.

The average age of youth, age range and percentage of males versus females continues to be stable among the CAMHD population. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. The majority of youth, as seen in Table 2 were male (65%). The proportion of males to females has been fairly consistent over time, and is largely reflective of national data for youth with serious emotional issues.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	674	35%
Males	1,276	65%

National Origin of youth is displayed in Table 3. CAMHD reports on this data as consistent with national standards. The races of youth registered in the reporting quarter are displayed in Table 4 Multiracial youth represented the largest racial group (61.7%), followed by White youth (17.7%), and then Native Hawaiian or Pacific Islanders (10.5%). Race data was not available (no data entered) for 44.5% of youth registered. Race data is more available this quarter than last when only 49% had race data recorded, and reflect the continued implementation of the new race and ethnicity recording system developed as part of the data infrastructure grant to meet federal reporting requirements.

Table 3. National Origin of Youth (Unduplicated)

National Origin	N	% of Available
Not Hispanic	463	69.2%
Hispanic or Latino/a	206	30.8%
Not Available (% Total)	1,281	65.7%

Table 4. Race of Youth (Unduplicated)

Race	N	% of Available
American Indian or Alaska Native	1	0.1%
Asian	81	7.5%
Black or African-American	15	1.4%
Native Hawaiian or Pacific Islander	114	10.5%
White	192	17.7%
Other Race	11	1.0%
Multiracial	668	61.7%
Based on Observation	146	13.5%
Not Available (% Total)	868	44.5%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 9.6% were involved with DHS, 23.4% had a Family Court hearing during the quarter, and 6.3% were incarcerated at HYCF or detained at the Detention Home at some point during the quarter. These data have been fairly consistent over time.

Table 5. Agency Involvement

Agency Involvement	N	%
DHS	188	9.6%
Court	457	23.4%
Incarcerated/Detained	123	6.3%
SEBD	639	32.8%
Quest	727	37.3%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occurs by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 639 and were 32.8% of the registered population. This was an increase of 185 youth, or a 41% increase in the SEBD category over the previous quarter (January 2005-March 2005).

QUEST-eligible youth who received services in the quarter were 37.3% of the population. The total number of QUEST enrolled youth increased from last quarter, when 675 youth with QUEST insurance were registered with CAMHD (36% of the registered population). QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or court-ordered status.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	803	45.5%
Attentional	753	42.7%
Mood	633	35.9%
Miscellaneous	449	25.4%
Anxiety	326	18.5%
Substance-Related	273	15.5%
Adjustment	210	11.9%
Mental Retardation	38	2.2%
Pervasive Developmental	28	1.6%
Multiple Diagnoses	1,268	71.8%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (45.5%), Attentional disorders (42.7%), and Mood disorders (35.9%). This quarter continued to see an increase in the number of youth identified with Disruptive Behavior disorders, representing the second quarter that there have been more youth with Disruptive disorders than those with Attentional disorders. Miscellaneous diagnoses accounted for 25.4% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 71.8% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight increase from the previous quarter (January 2005-March 2005) when 71.3% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (76.7%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 15.5% of the registered population, an increase of .3% from the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (April 2005-June 2005). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served received services provided in the home and/or community, which consist of Intensive In-Home services (47.1%) and Multisystemic Therapy (MST) (13.7%). The percentages of youth receiving services in these in-home categories decreased by .7% for Intensive In-Home and by .3% for Multisystemic Therapy over the last quarter's percentages.

Table 7. Service Authorization Summary (April 1, 2005-June 30, 2005).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	8	0.4%	0.8%
Hospital Residential	25	42	2.2%	4.0%
Community High Risk	10	12	0.6%	1.1%
Community Residential	129	163	8.4%	15.5%
Therapeutic Group Home	81	97	5.0%	9.2%
Therapeutic Family Home	136	157	8.1%	14.9%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	104	145	7.4%	13.7%
Intensive In-Home	410	497	25.5%	47.1%
Flex	120	185	9.5%	17.5%
Respite	26	30	1.5%	2.8%
Less Intensive	86	171	8.8%	16.2%
Crisis Stabilization	9	24	1.2%	2.3%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (15.5%). The percentage of youth receiving these services increased slightly from the previous quarter's (January 2005-March 2005) authorizations

for 15.3% of the registered population. The use of Hospital-based Residential services increased from 3.4% in the last reporting quarter to 4% this quarter (April 2005-June 2005), and is an important trend to watch as utilization of this service has been steadily increasing over time. Youth receiving treatment while in Therapeutic Family Homes accounted for 14.9% of those served (slightly up from the previous quarter's 14.4%), and Therapeutic Group Homes 9.2% (down from 9.5% in the previous quarter).

In the reporting period, services paid for through Flex funding were provided for 17.5% of registered youth, which was comparable to last quarter's utilization of these services for 17.9% of the registered population. CAMHD uses the term "Ancillary Services" for services paid for through flex funding. Ancillary Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. The largest use of Flex funding was to pay for travel cost for youth in out of home settings.

There were no youth accessing Respite Home services this quarter, which is the same as last quarter. Respite Homes were designed to support caregivers capacities and prevent potential out-of-home placements. Low utilization of this service over time implies potential barriers to youth accessing this service. There was also no utilization of Intensive Day Stabilization, Partial Hospitalization or Day Treatment Services. Respite services, which are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature, were authorized at approximately the same level they have been historically, with 2.9% of youth accessing these services in the quarter.

Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the third quarter of fiscal year 2005 (January 2005-March 2005). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Out-of-Home residential treatment services in Hawaii, including Hospital-Based Residential treatment, accounted for 83.0% of service expenditures, which is .6% above the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 1.4% of total expenditures, which is the same as the previous reporting quarter's (October 2004-December 2004) proportion of cost.

Table 8. Cost of Services (January 2005-March 2005)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	156,311	22,330	154,148	22,021	1.4%
Hospital Residential	1,254,862	39,214	1,023,146	31,973	9.1%
Community High Risk	456,521	41,502	426,195	38,745	3.8%
Community Residential	4,362,655	27,612	3,959,058	25,057	35.0%
Therapeutic Group Home	2,467,507	25,438	1,950,980	20,113	17.3%
Therapeutic Family Home	2,436,789	16,138	2,008,346	13,300	17.8%
Respite Home	23,462	11,731	800	400	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	968,946	6,547	424,023	2,865	3.8%
Intensive In-Home	2,299,665	5,077	1,008,346	2,226	8.9%
Flex	4,297,192	22,857	243,535	1,295	2.2%
Respite	133,250	3,701	42,113	1,170	0.4%
Less Intensive	128,961	16,120	12,409	1,551	0.1%
Crisis Stabilization	139,698	8,731	48,221	3,014	0.4%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). [b] Cost per LOC represents unduplicated cost (US$) for services at the specified level of care.

Hospital-Based Residential Services saw a significant increase in all categories over the last reporting quarter. The total cost of the service increased from $461,442 to

$1,254,862 and the cost per youth increased from $13,572 to $39,214. These data reflect a problem with billing in previous quarters that caused the cost to be reflected in a different quarter from when the services were provided. Therefore, the data presented here does not reflect the cost of services actually utilized in the quarter for this level of care.

The cost of Community-Based Residential (CBR) Services decreased slightly in the reporting quarter. The cost for CBR services has been relatively stable over the past several quarters. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($41,502 per youth), which has been consistent over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($16,138 per youth), which again, has been consistent over time.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 12.7% of the unduplicated cost of services, which is a slight decrease from the last reporting quarter (October 2004-December 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $5,077 per youth ($2,226 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

Youth who received Ancillary Services through Flex funding during the quarter had a cost of $22,857 per youth. These youth most commonly receive other treatment services in addition to those flexibly funded. The total cost for Flex-funded services alone was $1,295 per month. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel-related including family visits when placement is off-island. CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

Although the Memorandum of Agreement (MOA) between CAMHD and DDD ended in June 2004, the provision of services, supports and coordination for youth with mental retardation and developmental disabilities continued for the target population.

Respite Services

For April, May, and June, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Service—DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows updated utilization of various DDD services that families accessed to meet their needs.

Table 9. Other Service Options Utilized by Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	55
**POS - Partnerships in Community Living (PICL)	0
***DDD Respite	36
****Family Support Services Program (FSSP)	11

* Waiver admission as of 6/30/05
** PICL referrals for period of 4/1/05 – 6/30/05
* **DDD Respite (CAMHD recipients who applied in open enrollment of January 2005)
****FSSP enrolled 4/1/05 - 6/30/05

Table 10. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - June 2005)			$337,020.43

While families accessed DDD service options, there were no respite expenditures for the period April, May, and June. The total dollars expended for the target population since July 2002 is $337,020.43.

Residential Services

DDD has extended the Individual Community Residential Support (ICRS) contract for one year. ICRS currently provides for special treatment facility services for one youth.

All but one of the thirteen youth in the original target population receiving ICRS services have been admitted to the HCBS DD/MR waiver program. This individual continues to receive psychiatric treatment and hospital-based residential services, however discharge has been recommended and a transition plan for community-based residential supports is being addressed. It is projected that this individual will be discharged from the psychiatric treatment facility in the next quarter.

Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

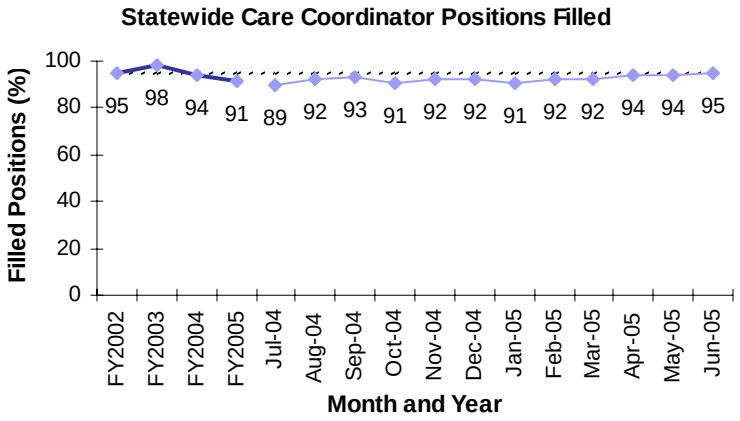
Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ **95% of mental health care coordinator positions are filled***

Over the reporting period, CAMHD had an average of 94% of care coordinator positions statewide filled, which was 1% below the performance goal. This performance is slightly above last quarter's average of 92% of positions filled. It should be noted that the quarter ended with 95% of positions filled, which met the goal. The overall increase in performance was due to a re-evaluation of vacant positions versus an increase in hiring. This quarter's results reflects the seventh consecutive quarter the performance goal was not met since this indicator began to be reported at the start of FY 2002. The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to impact performance on this goal.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	87%	94%	100%	100%	98%	88%

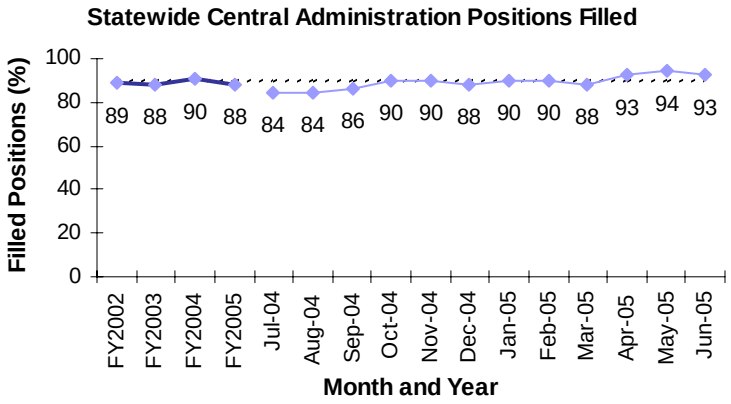
Vacancies in Central Oahu, Leeward Oahu, Maui, Hawaii, and Kauai impacted the Statewide average over the last quarter. Each of these FGCs experienced one to two vacancies.

Goal:

⇨ 90% of central administration positions are filled*

The performance target met the desired performance with an average of 93% of central administration positions filled over the quarter. This is above last quarter's performance of 89%, and is the first time the goal was met since fiscal year 2004. Similar to filled care coordinator positions, the increase in actual performance reflects the re-evaluation of vacant positions, and not the filling of more positions. Central Administration positions provide support for the infrastructure and quality management functions necessary to manage the statewide service system. Because these positions are vital to maintaining the service system, a higher than 90% threshold may need to be considered.

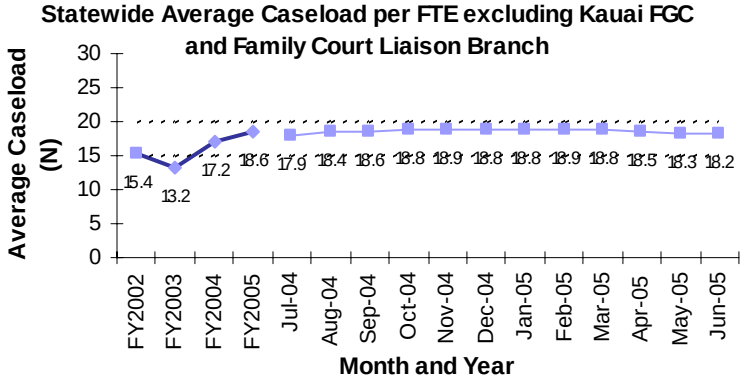
Most of the vacant positions continue to fall in the Management Information System section, which impacts the ability to develop the information system for clinical decision-making. The Transition Specialist position in the Clinical Services Office continues to be unfilled due to the inability to recruit a qualified candidate.



Goal:

⇨ **Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.**

The statewide average caseload for the fourth quarter was within the target range at 18.3 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have consistently been in the targeted range since the beginning of fiscal year 2004.



The average caseload performance target was not met for Central Oahu, Leeward Oahu, and the Big Island FGCs where caseloads were one above the expected range. This year saw the highest caseload average since reporting on this measure began in FY 2002, and the first time half of the FGCs have gone over the performance target.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
4th Quarter Average	21	21	14	17	17	21

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is January 2005-March 2005, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the reporting quarter was under projection by $407,000. Sufficient funds were encumbered for all expected service costs.

Expenditures for Branch and Services totals were below budget. The total variance from the budget for FY 2005 was under projection by $325,000.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	2004.1	2004.2	2004.3	2004.4	2005.1	2005.2	2005.3
Branch Total	$164	-$150	$20	-$218	$134	$62	-$54	-$60	$20	-$337	-$338
Services Total	$798	-$4,175	-$1,849	-$120	$59	-$3,963	-$3,389	-$101	-$2	-$203	-$155
Central Office Total	-$189	-$388	-$314	$14	-$226	-$298	-$344	-$388	-$15	-$30	$86
Grand Total	$773	-$4,713	-$2,142	-$325	-$33	-$4,200	-$3,787	-$549	$4	-$571	-$407

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days

This quarter, 97% of contractors were paid within the 30-day window over the quarter. This is an increase over last quarter's average of 87% of contracted providers paid within 30 days, and meets the performance goal. The data reflect only one invoice in the quarter that was paid beyond the 30-day benchmark.

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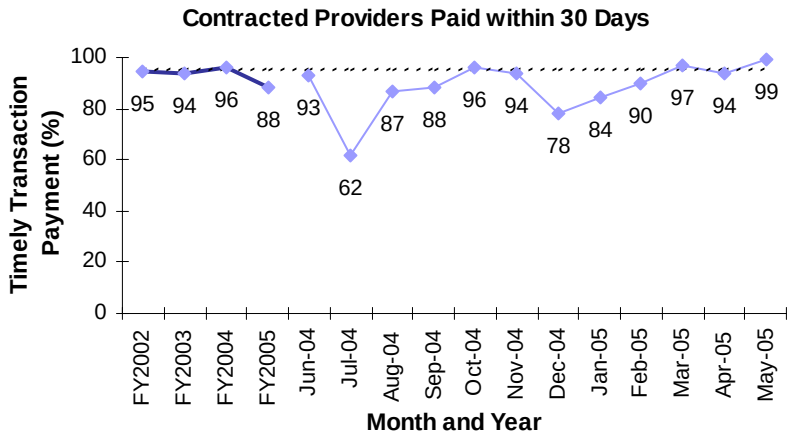


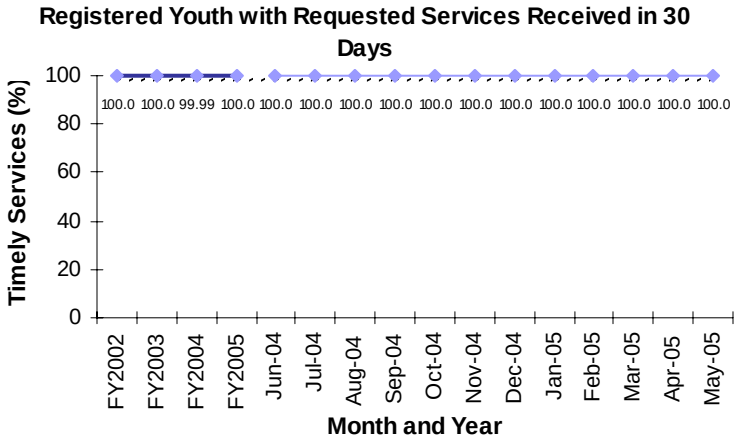
Because of previous issues in timely payment, the CAMHD Fiscal Section implemented measures to expedite the internal claims review and vouchering process and increased the use of a procedure to shorten the processing time through DAGS. The year ended with providers paid within 30 days 88% of the time. As standard for reporting, the quarter's data is available for the first two months of the quarter (April and May 2005) and includes March 2005.

CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ **98% of youth receive services within thirty days of request***

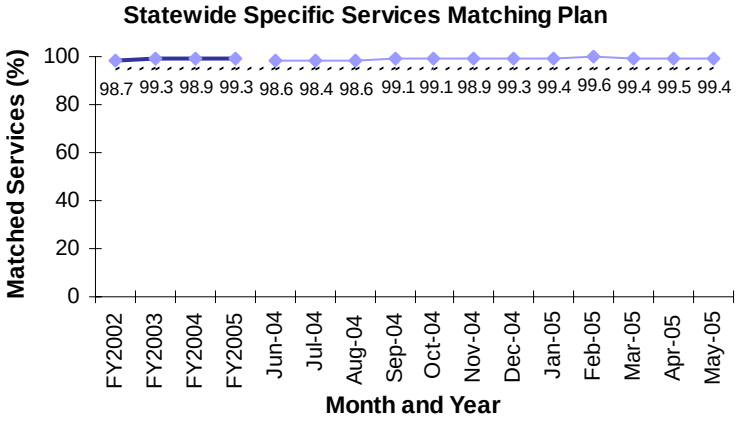
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (April and May 2005) as third month data are not available at the time of publication. March 2005 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.



Goal:

⇨ **95% of youth receive the specific services identified by the educational team plan***

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.4% of youth received the specific services identified by their team plan. These youth received services within 30 days, but they were not the exact service selected by their service teams. Data are for the first and second month of the reporting quarter (April and May 2005) as third month data are not available at the time of publication. March 2005 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



In the quarter, service mismatches occurred in twelve complexes versus eight in the previous quarter. Hilo, Baldwin Complexes and Olomana each had two youth receiving mismatched services. The remaining complexes

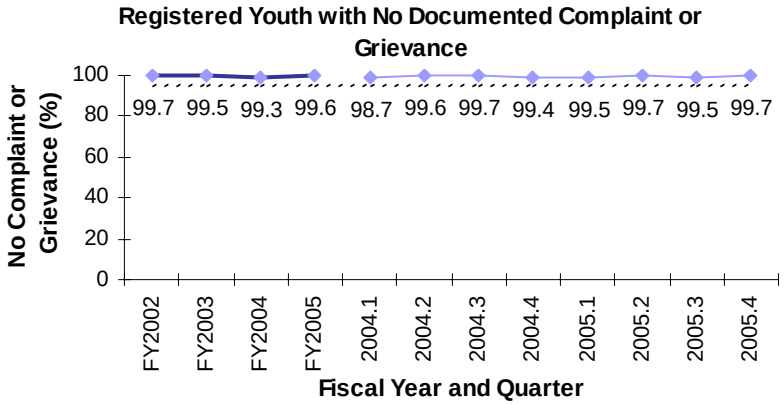
experiencing mismatches had one a piece. Hilo and Pearl City were the only two complexes that had continuing mismatches. Hilo has had mismatches for the last eight quarters (since June-August 2003), and Pearl City has had mismatches over the last four quarters (since June-August 2004).

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ **95% of youth served have no documented complaint received***

99.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

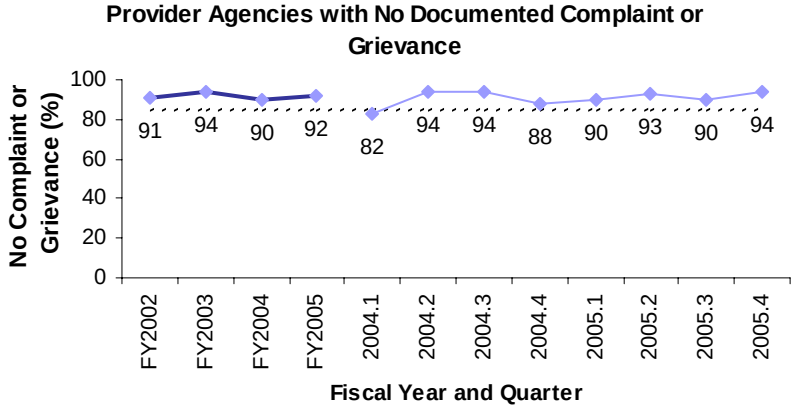


In the quarter, there were complaints received from 10 youth (or someone complaining on their behalf) representing 8 complexes statewide as compared to 5 youth with documented complaints representing 5 complexes last quarter. There was one complaint for each of the following complexes: Waianae, Kaimuki, Maui High, Molokai, and Laupahoehoe. Three complaints were received for youth attending charter schools. Beyond this, there were no noticeable trends in the data.

Goal:

⇨ **85% of provider agencies have no documented complaint received**

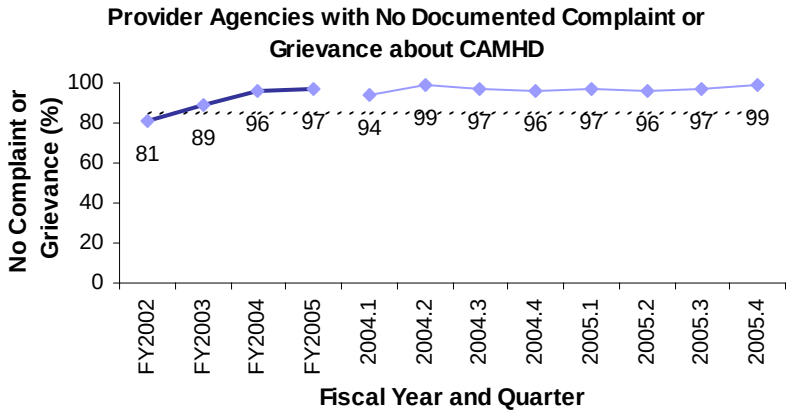
94% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 99% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

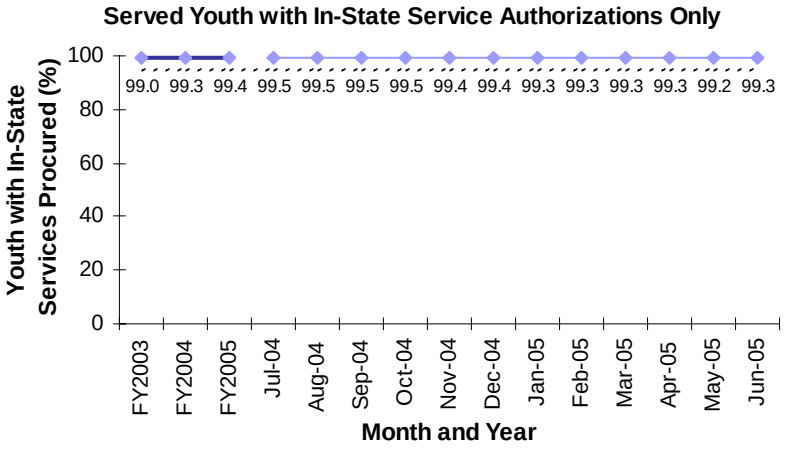


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

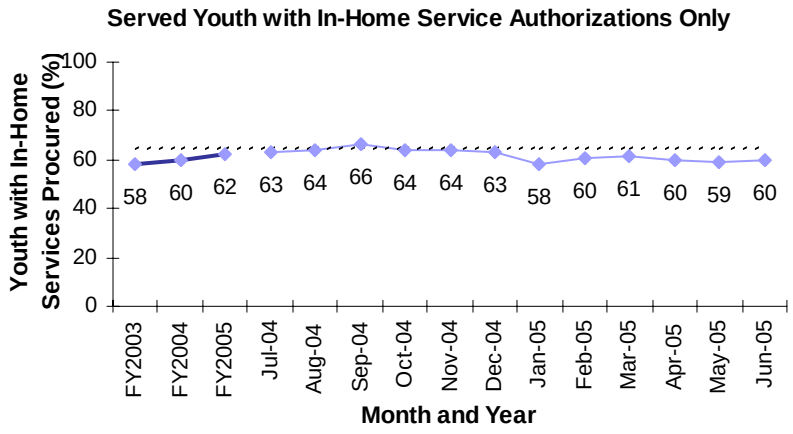
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Seven youth received services in out-of state treatment settings in the first month of the quarter, and six in the last two. These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by other State agencies.



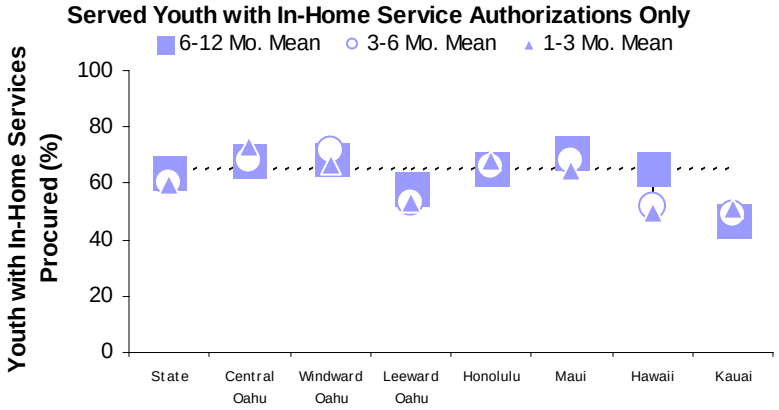
Goal:

⇨ **65% of youth are able to receive treatment while living in their home**

An average of 60% of youth were served in their home communities during the quarter, which was 5% below the performance goal. This quarter's performance is the same as last quarter's.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu FGC (72.9% served in their homes), Windward Oahu (66.6% served in-home), and Honolulu FGC (67.8% served in-home). All FGCs that did not meet the benchmark, or had declining performance will be asked to review the data in their next QA Committee meeting.



Serving youth in their homes and home communities whenever possible continues to be a core value for CAMHD. Efforts to assure youth are served in the least restrictive, most appropriate environment are currently underway through a quality improvement activity being monitored through CAMHD's Performance Improvement Steering Committee.

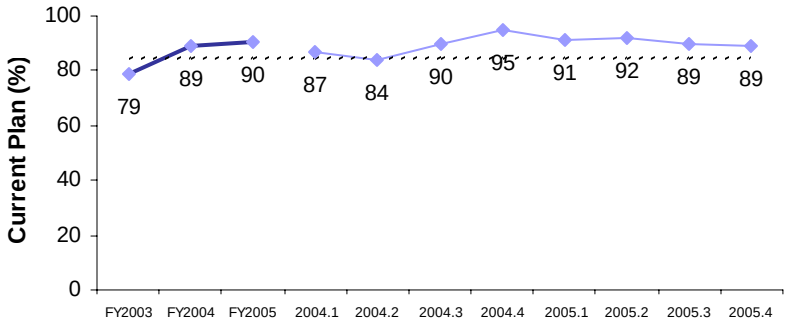
CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ **85% of youth have a current Coordinated Service Plan (CSP)***

CAMHD's performance in this measure met the performance goal for the reporting quarter with 89% of youth across the state having a current CSP, which was the same as last quarter's performance. The goal has been met for the past two fiscal years.

Average Coordinated Service Plan Timeliness



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

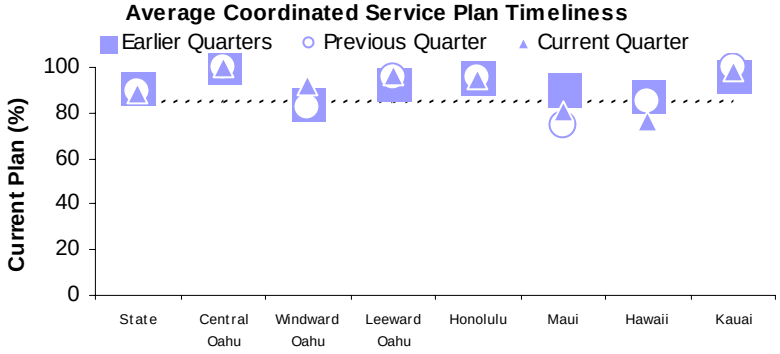
"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
100	97	80	92	95	76	98

Trend data for each FGC are displayed below. Maui (80%) and Hawaii (76%) FGCs did not meet the performance goal in the reporting period. As can be seen below. Maui improved in timeliness since the last quarter, but Hawaii's performance declined. Maui expects that the filling of a vacant MHCC position and increased supervision supports will address the timeliness issues. The Big Island also will increase supervision and is filling a vacant Mental Health Supervisor position.

Average Coordinated Service Plan Timeliness

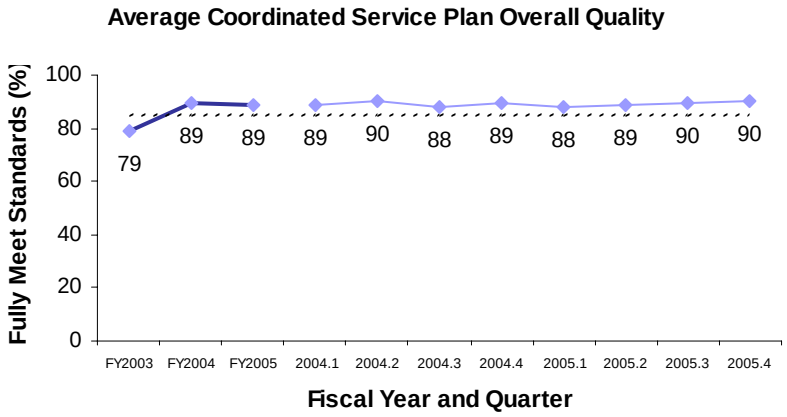


Goal:

⇨ **85% of Coordinated Service Plan review indicators meet quality standards***

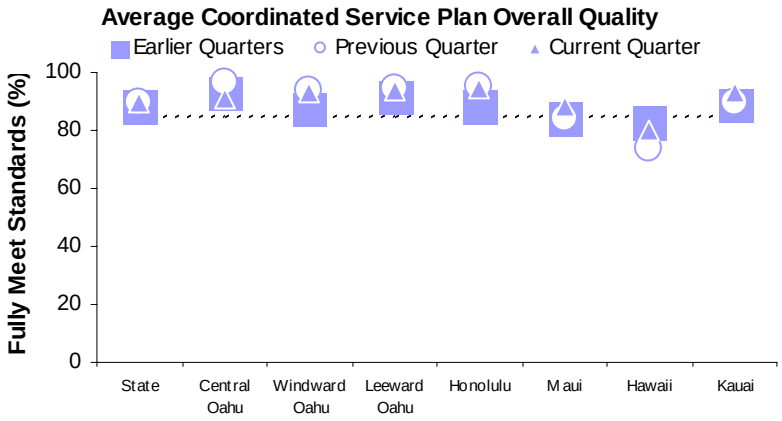
The goal for this measure was met in the reporting quarter with 90% of CSPs sampled statewide meeting overall standards for quality. The goal has been met for the past two fiscal years.

The statewide data for quality of CSPs are displayed below:



CSPs are reviewed quarterly by the FGCs for meeting standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures.

As seen in the next chart, the goal was met or exceeded by all FGCs with the exception of Hawaii FGC, which experienced an improvement in the quality of their CSPs, but did not meet the goal. The FGC has developed strategies in its Quality Assurance Committee that include focused supervisory feedback, a booster training and use of inter-rater reliability to increase quality discernment.



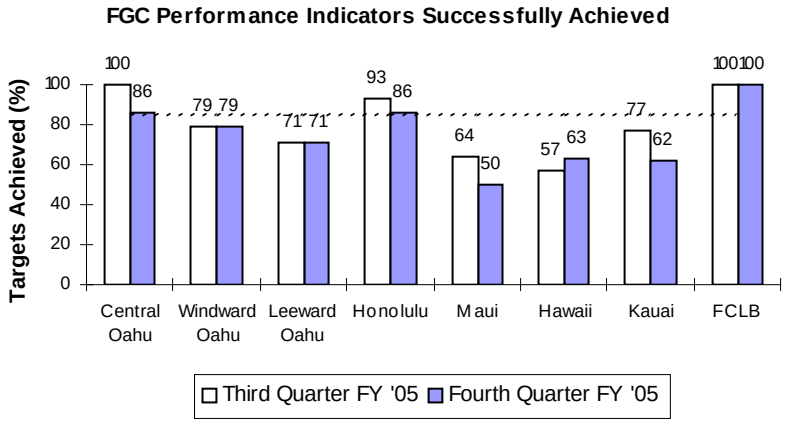
Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ **85% of performance indicators are met for each Family Guidance Center**

Three of the eight Family Guidance Centers met the goal this quarter. Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction.

The goal of meeting at least 85% of the performance indicators was met by Central and Honolulu FGCs and the Family Court Liaison Branch (FCLB).



On average across all FGCs, 74.6% of all goals were met in the quarter, compared to 80.1% in the last quarter, and 73% in the previous quarter. Windward, Leeward, Maui, Hawaii, and Kauai FGCs did not meet performance goals. Hawaii FGC showed improvement over the previous quarter's performance.

The Family Guidance Centers did well in indicators of:

- maintaining within their budgets,
- timely access to services,
- documented complaints from consumers,
- serving youth in the State,
- Coordinated Service Plan quality,
- complexes that did well on Internal Reviews
- youth showing improvements as measured by the CAFAS or ASEBA, and
- youth with acceptable Child Status in Internal Reviews.

As a whole they did moderately well in timeliness of Coordinated Service Plans.

Generally, the FGCs struggled with:

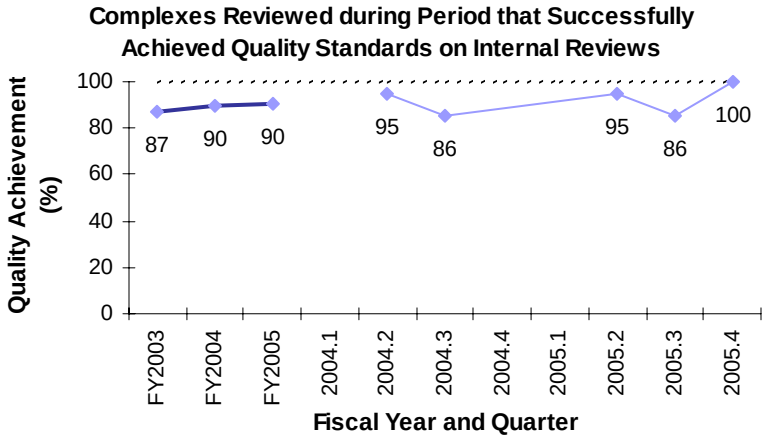
- filling their care coordinator positions,
- average caseloads,
- serving youth while they are living at home,
- completing the CAFAS or ASEBA, and
- family satisfaction.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ **100% of complexes will maintain acceptable scoring on internal reviews.***

The performance target, which is a joint DOE-DOH measure, is for all complexes to achieve the goal. In the quarter, only Kealakehe Complex was reviewed, and the goal was achieved. During the year, 90% of complexes achieved the performance goal of acceptable system performance at 85% or better.

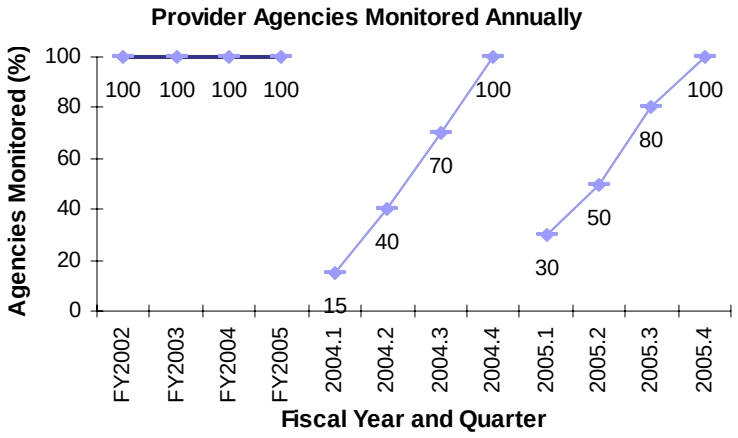


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ **100% of provider agencies are monitored annually**

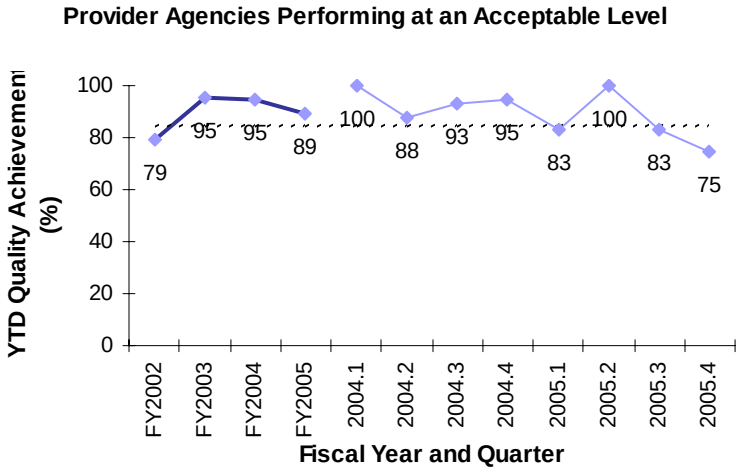
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the fiscal year, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Four agencies, representing nine contracts and seven levels of care were monitored in the fourth quarter.



Goal:

⇨ **85% of provider agencies are rated as performing at an acceptable level**

In the reporting quarter, 75% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which was below the performance goal. Provider agencies are reviewed across multiple dimensions of quality and effective practices. One agency, at the community-based residential level of care, was found to have a number of issues impacting its overall performance and ability to provide quality services on a consistent basis. Corrective actions had been requested and the current status of this agency is under review by the CAMHD Executive Management Team.

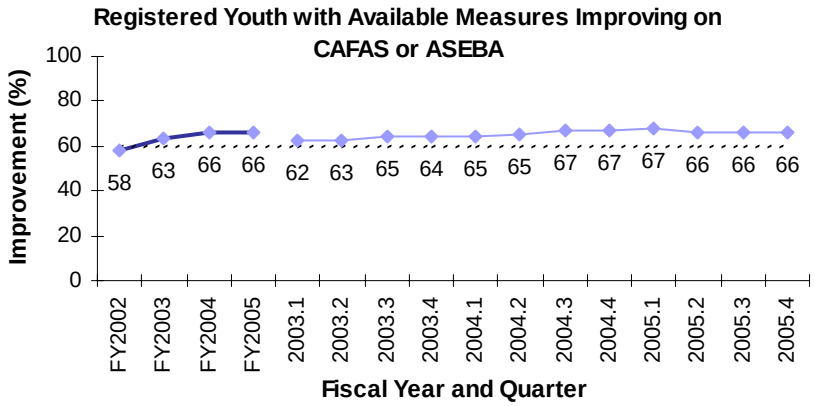


CAMHD will demonstrate improvements in child status

Goal:

⇨ **60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)***

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%. As performance on this measure has stabilized over the past two years, it is recommended that a higher benchmark be established.

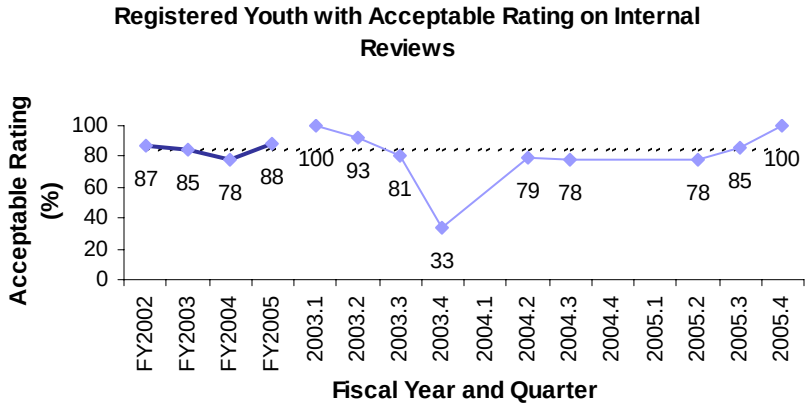


In the reporting quarter, for youth with data for these measures, 66% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a fairly steady trend in functional improvements for youth served by CAMHD over the past three years.

Goal:

⇨ **85% of those with case-based reviews show acceptable child status**

Of youth receiving care coordination and services through CAMHD, 100% were found to be doing well in measures of child well-being, which meets the performance goal for this measure. Child status as measured by Internal Reviews has met the benchmark for two consecutive quarters, and the overall average for the year (88%) also meets the targeted performance level.

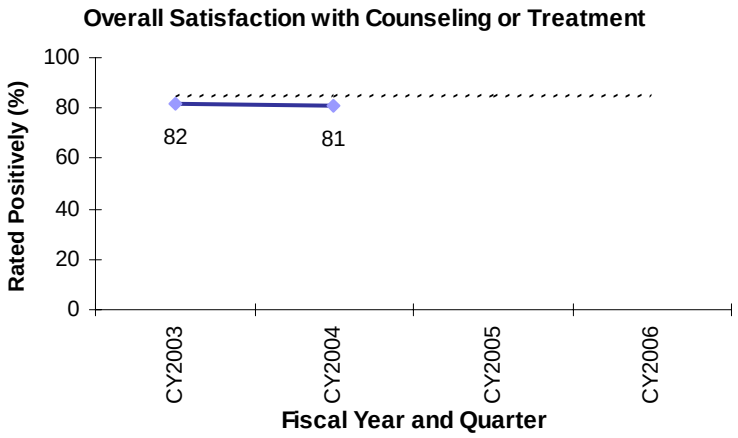


Families will be engaged as partners in the planning process

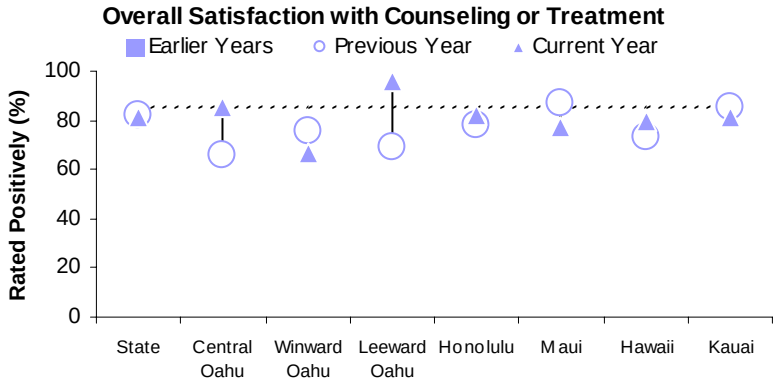
Goal:
⇨ **85% of families surveyed report satisfaction with CAMHD services**

CAMHD uses the Experience of Care and Health Outcomes (ECHO™) survey. The survey was selected because it builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. It assesses consumer experiences with a number of aspects of care including quick access to care, communication with clinicians, information provided by clinicians, consumer involvement in treatment, information about treatment options, and the behavioral health organization's administrative services. The survey collects useful information about the characteristics of youth and their families. Satisfaction and consumer experiences with services are important for mental health delivery systems to understand in working toward optimal care and outcomes. The comprehensive report of this year's survey results (assessing satisfaction for calendar year 2004) can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs005.pdf.

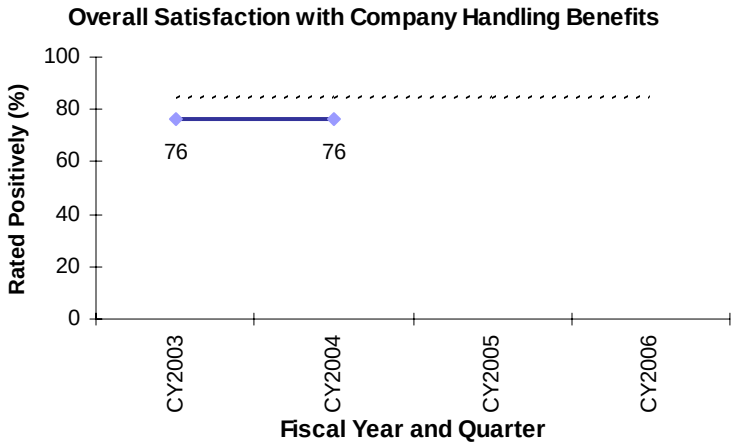
Results regarding two aspects of overall satisfaction are presented below. The survey found that 81% of CAMHD caregivers were satisfied overall with their child's counseling or treatment, which is slightly below the previous years satisfaction in this measure.



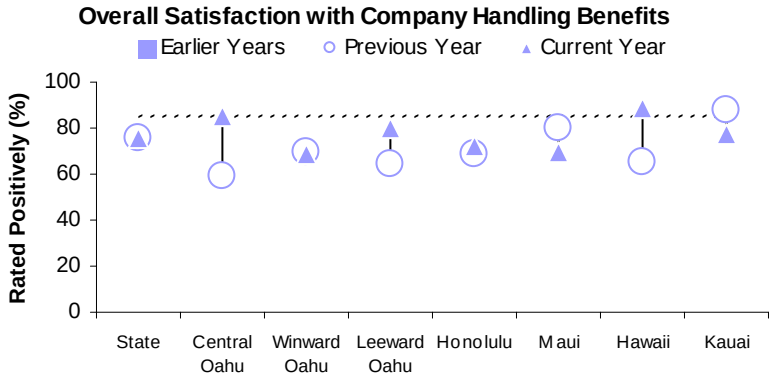
The comparison between calendar year 2003 and 2004 data for each Family Guidance Center is seen below. Central and Leeward FGCs met the performance goal. There were improvements in satisfaction with counseling/treatment for Central, Leeward, Honolulu and Hawaii FGCs. There were declines in satisfaction with counseling/treatment for Windward, Maui and Kauai.



Another key measure of satisfaction falls under the title of "Overall Satisfaction with the Company Handling Benefits." This question allowed respondents to rate their overall satisfaction with the service system's management of their child's behavioral health care. Results for this indicator fell below targeted performance with 76% of those surveyed satisfied with CAMHD's handling of their child's care, which is the same as the previous year's performance. The detailed analysis provided in the survey helps CAMHD to identify needed improvements in managing care for consumers. Identification of systemic improvement efforts to impact consumer satisfaction have been assigned to a taskforce chaired by the CAMHD Medical Director and Performance Manager.



Results for the individual FGCs and a comparison to the previous year's data are presented below. Satisfaction goals were met for Central and Hawaii FGCs. Improvements in satisfaction with the FGC were seen for Central, Leeward, and Hawaii FGCs. Similar to satisfaction with counseling/treatment, there was a decline in satisfaction with the FGC for the Maui and Kauai FGCs.

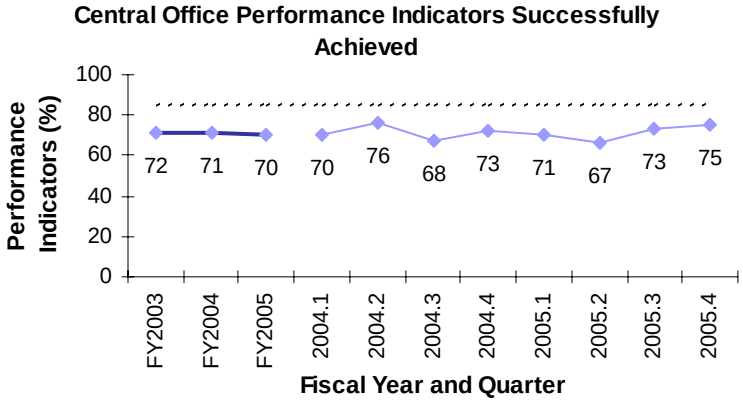


There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ **85% of CAMHD Central Office performance measures will be met.**

CAMHD's Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 38 measures currently tracked by EEMT. Of the 32 applicable measures, 24 or 75% of measures were successfully met in the fourth quarter, which falls short of meeting the performance goal for this quality indicator, but shows a slight increase over last quarter's performance. The long-term pattern for this indicator is for the mean performance to fluctuate around 70%. These measures have historically been unable to meet the performance goal. In the quarter, the measures that fell below their goals continued to revolve around timeliness and issues related to the impact of staff vacancies.

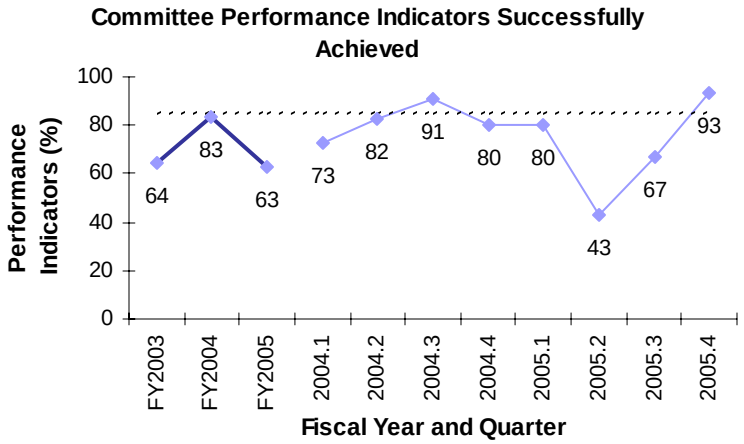


Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Complaints & Grievance, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.



A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 14 applicable measures, 93% were met through the work of the CAMHD Committees, which met the goal for this quality indicator. This is an improvement over last quarter's performance of 67% of measures met, and is the first time the goal has been met since the third quarter of Fiscal Year 2004. Two of the Evidence-Based Services committee's measures (article coding and target areas) for this quarter did not meet the performance goal. Each committee not meeting their benchmark is required to present improvement strategies to PISC. A more in-depth analysis of the drop and recovery of this indicator over the past several quarters in being conducted.

Summary

The majority of performance goals were met or exceeded in the fourth quarter of fiscal year 2005 (April 2005-Juen 2005). For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "sustainability measures," indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 2% below targeted performance and an improvement by 1% over last quarter's performance.

The following were measures that met or exceeded goals:

- Filled Central Office positions*
- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Central Oahu Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*
- Monitoring of provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*
- Child Status as measured by Internal Review Results
- State Committees' (Performance Improvement Steering Committee) performance indicators performance indicators

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Filled Care Coordinator positions*
- Youth receiving treatment while living in their homes
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits
- Central Office Performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Quality service provision by provider agencies

CAMHD continued to experience stable performance in most of its measures of performance. Of the 31 measures discussed in this report, 20 or 64% of performance indicators met or exceeded goals. Measures that did not meet goals but had stable or improving trends constituted 23% (7 measures), and 4 or 13% did not meet goals and had declining performance. Of the original "Sustainability" measures, only one (Filled Care Coordinator positions) did not meet its performance goal, versus three in the last quarter. Challenges to filling positions in the Central Office have been largely addressed with the exception of specialist positions in the Clinical Services Office and MIS positions. These vacancies continue to hamper operations in these sections. Additionally, performance areas of concern in the Family Guidance Centers are largely impacted by vacancies and the time it takes to fill positions.